MARYLAND HEALTH CARE COMMISSION

Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations

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Executive Summary

The Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations (the "Task Force") was created by the Maryland General Assembly in its 1999 legislative session with the passage of Senate Bill 585 (SB 585). The Task Force was charged with the development of measures of quality for the provision of *behavioral health care services* to members or enrollees of *managed behavioral health care organizations. Managed behavioral health care organizations* are defined as "a company, organization, or subsidiary that: contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to members; or otherwise makes behavioral health care services available to members through contracts with mental health care providers." *Behavioral health care services* are defined as "procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, drug abuse, or alcohol abuse."

Task Force membership consists of ten members including the Secretary of the Department of Health and Mental Hygiene or the Secretary's designee, the Executive Director of the Maryland Health Care Commission (MHCC) who is designated the Chairman, and the Maryland Insurance Commissioner. The remaining seven were appointed by the MHCC based on nominations from professional associations or groups designated in the bill.

The Task Force was appointed by MHCC prior to the effective date of the legislation in order to ensure a prompt start to the deliberations given the short period for report. The Task Force met five times from October through December, about twice monthly.

Over the brief period of three months, the Task Force covered a number of topics. These included an overview of the law currently governing the activities of MBHOs, and presentations on performance data currently available, including NCQA's Health Plan Employer Data and Information Set (HEDIS), and the academic community's assessment of the current state of the art in performance reporting. The MBHOs who are participating in the Task Force also reviewed with members current data systems' capacity. The subjects of patient satisfaction surveys and reporting of complaints and grievances were also addressed.

Thus far, the Task Force has concluded that while several types of measures of quality of performance are available, there are few tools that are well developed or validated as having a quantitatively demonstrable relationship to quality. For that reason, the Task Force is recommending that, with the exception of a few initial steps, the deadline for final recommendations be extended to December 15, 2000 in order to permit a more thorough analysis of the measures that should be reported.

This interim report is intended to address several questions including:

- How are MBHOs regulated?
- What is the structure of the MBHO industry?
- What are measures of quality assessment?
- What databases are currently available on behavioral health services?

In making its initial recommendations, the Task Force discussed and debated a series of key questions in performance reporting. The Task Force unanimously agreed that performance reports should address the needs of multiple audiences including consumers, providers, businesses, HMOs, and MBHOs. The Task Force also recommends the following:

1. **Request permission to delay final recommendations until December 15, 2000. Submit an interim report to the Maryland General Assembly on December 15, 1999.**

2. **Take a three-pronged approach to quality performance reporting.**

   a. **Identify in the interim report what is currently available and could be included in the HMO performance report in 2001;**

   b. **Decide in the final report what types of measures would be desirable and are feasible to develop; and**

   c. **Identify those indicators that would be desirable to develop, but are not currently feasible to report due to data collection, measurement issues, or cost.**

3. **Indicate the following in the 2001 MHCC HMO report card:**

   a. **HMOs that have behavioral managed health services in-house versus those who carve out these services;**

   b. **Mental health related HEDIS measures reported by commercial HMOs; and**

   c. **Accreditation status for carve-outs.**

4. **By 2001, attempt to combine and report HEDIS HMO mental health measures by MBHOs.**

5. **For the final report, the Task Force should:**

   a. **Explore how to expand quality measures beyond HMOs to fully insured plans;**

   b. **Determine usefulness and feasibility of collecting outcome measures;**

   c. **Determine the usefulness and feasibility of collecting information on patient satisfaction; and**

   d. **Determine the usefulness of reporting internal and external complaints. Internal complaints could be recorded and categorized by MBHOs; external complaints could be obtained from the MIA through their Appeals and Grievance Process or the Department of Health and Mental Hygiene.**

TASK FORCE TO DEVELOP PERFORMANCE QUALITY MEASURES FOR MANAGED BEHAVIORAL HEALTH CARE ORGANIZATIONS

I. Introduction

The Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations (the "Task Force") was created by the Maryland General Assembly in its 1999 legislative session with the passage of Senate Bill 585 (SB 585). The Task Force was charged with the development of measures of quality for the provision of *behavioral health care services* to members or enrollees of *managed behavioral health care organizations. Managed behavioral health care organizations* are defined as "a company, organization, or subsidiary that: contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to members; or otherwise makes behavioral health care services available to members through contracts with mental health care providers." *Behavioral health care services* are defined as "procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, drug abuse, or alcohol abuse."

Task Force membership consists of ten members including the Secretary of the Department of Health and Mental Hygiene or the Secretary's designee, the Executive Director of the Maryland Health Care Commission (MHCC) who is designated the Chairman, and the Maryland Insurance Commissioner.[1] The remaining seven were appointed by the MHCC based on nominations from professional associations or groups designated in the bill. Appendix A contains the names and affiliations of the Task Force members.

By statute, the Task Force must consider the following when developing the quality measures:

1. Discharge rates for members or enrollees who receive *in-patient* mental health and substance abuse services;
2. The average length of stay for members or enrollees who receive *in-patient* mental health and substance abuse services;
3. The percentage of enrollees receiving *in-patient* and *out-patient* services for mental health and substance abuse;
4. Readmission rates of members and enrollees who receive *in-patient* mental health and substance abuse treatment;
5. The level of patient satisfaction with the quality of managed behavioral health care services received; and
6. Any other quality measures that the Task Force deems appropriate.

These provisions of law are actually part of a broader statute intended to focus on several aspects of the relationship between carriers (HMOs and insurers) and their providers of behavioral health care. The statute directs carriers to annually file with the Commissioner of the Maryland Insurance Administration (MIA), a mental health expense ratio. This requirement does not apply when risk is not assumed by the provider of behavioral health services. The portion of the law

[1] When SB 585 was adopted, references were to the MHCC's predecessor organization, the Health Care Access and Cost Commission (HCACC).

relating to development of quality measures is intended to complement the provisions relating to cost.

The Task Force was appointed by MHCC prior to the effective date of the legislation in order to ensure a prompt start to the deliberations given the short period for report. The Task Force met five times from October through December, about twice monthly (Appendix B contains the meeting agendas and minutes).

Over the brief period of three months, the Task Force covered a number of topics. These included an overview of the law currently governing the activities of MBHOs, and presentations on performance data currently available, including NCQA's Health Plan Employer Data and Information Set (HEDIS), and the academic community's assessment of the current state of the art in performance reporting. The MBHOs who are participating in the Task Force also reviewed with members current data systems' capacity. The subjects of patient satisfaction surveys and reporting of complaints and grievances were also addressed.

Thus far, the Task Force has concluded that while several types of measures of quality of performance are available, there are few tools that are well developed or validated as having a quantitatively demonstrable relationship to quality. For that reason, the Task Force is recommending that, with the exception of a few initial steps, the deadline for final recommendations be extended to December 15, 2000 in order to permit a more thorough analysis of the measures that should be reported.

II. Regulation of Managed Behavioral Health Organizations

Maryland law and regulations governing managed behavioral healthcare organizations (MBHOs) are intended to assure that management of behavioral health and substance abuse treatment is based on industry standards. All MBHOs operate as "private review agents" under Maryland law (Insurance Article, Title 15, Subtitle 10B). If a MBHO enters into an agreement with an health maintenance organization (HMO) to provide behavioral health services for a fixed fee, the terms of the agreement are subject to Maryland law governing administrative service provider contracts (Health-General Article, Title 19, Subtitle 713.2). Assuring compliance with the law and regulations is the responsibility of the MIA.

All private review agents must obtain a certificate of registration from the Commissioner of the MIA. The certificate is issued only after applicants have met all the requirements set forth in law and in regulations. The law specifies the information that must accompany applications for certificate of registration as a private review agent. This information must address three issues: criteria and standards, the personnel performing the review, and patients' rights. Specific provisions relate to treatment of alcoholism, drug abuse or mental illness. First, all decisions related to medical necessity and place of service, including the original decision and decisions made as a result of an appeal, must involve at least one physician. In addition, the physician must meet certain qualifications. The second provision relates to treatment plan submission. MBHOs must accept the uniform treatment plan specified by regulation, without modification, and may not require any other treatment plan. MBHOs are required to approve treatment plans within a specified time period and offer protection for both providers and patients when an admission is an emergency or when the patient is in imminent danger. The regulations to

develop the “form” for the uniform treatment plan are currently being finalized by MIA so that this part of the law can be implemented.

The Insurance Commissioner is allowed, by law, to establish additional reporting requirements to evaluate the effectiveness of private review agents, and evaluate compliance with laws and regulations.

When a MBHO accepts payments from an HMO for providing behavioral health care services to HMO enrollees via contracts with providers, the MBHO is an "administrative service provider" (ASP) under Maryland law (cited above). HMOs that intend to contract with ASPs must first submit a plan to the Insurance Commissioner designed to assure that ASPs are able to reimburse the providers in their networks for patient care services. An HMO contracting with an ASP "shall" monitor the ASP for compliance with the plan and notify the ASP when non-compliance is found. In the event the ASP fails to reimburse providers, as required under the contract, the HMO is liable. The plan and related documents are confidential and proprietary.

Individual providers of behavioral mental health services are also regulated under Maryland’s Health Occupations Article by specific professional licensing boards. Licensed and certified mental health and substance abuse providers in Maryland are physicians, psychologists, social workers, nurse psychotherapists and professional counselors. There are four categories of social workers but only those licensed as "certified social worker-clinical" (LCSW-C) may render diagnosis of mental and emotional disorders.

There are three categories of *certified* professional counselors: certified professional counselor (CPC), certified professional counselor - alcohol and drug (CPC-AD), and certified professional counselor - marriage and family therapist (CPC-MFT). There are also three categories of *licensed clinical* counselors: licensed clinical professional counselor (LCPC), licensed clinical alcohol and drug counselor (LCADC), and licensed clinical marriage and family therapist (LCMFT). The qualifications for LCADCs include those for CPC-ADs plus academic study that includes: personality development; diagnosis and treatment of mental and emotional disorders; psychopathology; and psychotherapy in alcohol and drug disorders. An individual must be a LCADC to function independently in Maryland's public mental health system.

Behavioral health providers and the boards that license or certify them are presented in Table 1.

Table 1
Licensed/Certified Behavioral Health Providers

Providers	Licensing/Certifying Agency
Physicians (M.D.s)	State Board of Physician Quality Assurance
Psychologists (Ph.D.s)	State Board of Examiners of Psychologists
Certified Social Worker – Clinical (LCSW-C)	State Board of Social Work Examiners
Nurse Psychotherapists	Maryland Board of Nursing
a) Certified Professional Counselor – Alcohol and Drug (CPC-AD) b) Licensed Clinical Alcohol and Drug Counselors (LCADC)	State Board of Examiners of Professional Counselors

III. MBHO Industry

Seventy-two percent or 162.2 million of the estimated 225 million Americans with health insurance during 1998 were enrolled in some type of managed behavioral healthcare organization (MBHO) program. Approximately, 14.3 million additional Americans had behavioral health benefits provided through and managed internally by HMOs so that the total insured population with a managed behavioral health care component was 78%.[2]

A few MBHOs dominate the market nationally. In 1998, two MBHOs, Magellan Behavioral Health and Value Options, were responsible for over half of all MBHO enrollees and four, Magellan, Value Options, United Behavioral Health, and Managed Health Network were responsible for two-thirds. This domination is due largely due to recent industry mergers and acquisitions. Magellan Behavioral Health, the majority owner of Green Spring Health Services, purchased both Merit Behavioral Care and Human Affairs International (HAI) and is now responsible for more than one-third of the market. Options Health Care purchased Value Behavioral Health, the largest MBHO at that time, and is now responsible for one-sixth of the market.[3]

The purchaser of health insurance - a business or government - may assign the responsibility for the management of behavioral health care benefits directly to the managed care organization (MCO) providing the medical/surgical benefits, or the purchaser may elect to "carve out" the behavioral health benefit through establishment of an employee assistance plan (EAP). The MCO may manage the behavioral health benefits internally, carve them out by contracting with a MBHO, or combine these options. In an EAP, the purchaser contracts directly with an MBHO.

There are a variety of MBHO products defined by the services provided by the MBHO and the risk it assumes.

Utilization Review/Care Management (UR/CM): This is an ASO (administrative services only) product. The MBHO arranges for and manages treatment, and pays claims but does not maintain a network of providers or assume risk.

Network Products: These products, in addition to UR/CM, are characterized by a network of physicians and other practitioners who are MBHO staff, under contract to the MBHO, or both. The MBHO may also own behavioral health care facilities. As in other forms of managed care, patients must receive their care from network providers. Network products are of two types: risk-based and non-risk-based.

> *Risk-based*: The MBHO assumes all or a portion of the financial risk of providing care in exchange for capitation payments (a fixed amount per member per month) that may be adjusted to reflect the risk factors of the covered population.
> *Non-risk-based:* The MBHO assumes no financial risk of providing care. Apart from furnishing networks, the MBHO acts very much as in an ASO arrangement.

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[2] *Managed Behavioral Health Market Share in the United States, 1998-1999*, pp 10-12. OPEN MINDS, Gettysburg, PA. 1999

[3] ibid.

In a 1997 survey of Fortune 500 companies, 39% of responding firms (n = 339) indicated they contract directly with MBHOs. The carve-out rate varied significantly - from 7% to 55% - depending on the type of industry that was carving out this care. Most companies - 76% - do not put MBHOs at risk and only 6% put MBHOs at full risk.[4]

Table 2 identifies the MBHO used by each of the fifteen HMOs operating in Maryland whose 1997 premiums collected in Maryland exceeded $1,000,000.

Table 2
HMO-MBHO Affiliation

HMO	MBHO
Aetna U.S. Healthcare, Inc. – Maryland (AUSHC-MD)	Human Affairs International (HAI) - a Magellan Behavioral Health company[1]
Aetna U.S. Healthcare, Inc. – Virginia (AUSHC-VA)	Same
CapitalCare HMO	Health Management Strategies
CIGNA HealthCare	MCC Behavioral Care[2]
Columbia Medical Plan/ FreeState Health Plans	Green Spring Health Services[3]
Delmarva Health Plan	Same
Innovation Health	Integrated Behavioral Health
Kaiser Permanente	Sheppard Pratt Health System[4]
Optimum Choice	None[5]
NYLCare Health Plans	Human Affairs International (HAI)[6]
Preferred Health Network	CMG Health - a Magellan Behavioral Health company
Principal HealthCare	American PsychSystems[7]
Prudential HealthCare	Value Options
United HealthCare	United Behavioral Health[8]
George Washington University Health Plan	Metropolitan Psychiatric Group

Notes

1. The AUSHC representative notes that some control is retained over the MH/SA benefit; e.g., the first level of patient/provider appeal takes place within AUSHC.
2. MCC Behavioral Care is a CIGNA company.
3. Magellan Behavioral Health is the majority owner of Green Spring Health Services.
4. Effective August 1, 1999.
5. Optimum Choice uses an in-house, stand-alone managed behavioral healthcare unit called MAPSI.
6. Prior to its purchase by AUSHC, NYLCare used Merit Behavioral Health.
7. Principal provides oversight. ASO accounts choose their own MBHO.
8. The use of a MBHO is dictated by the insurance package purchased by an employer. Some packages do not carve-out the MH/SA benefit; others do. Both United HealthCare and United Behavioral Health are subsidiaries of the United Health Group.

[4] Garnick, Deborah, et al., *Fortune 500 Firms: Carve-Out Contracts With Behavioral Healthcare Vendors Preliminary Results*; Brandeis/Harvard Research Center on Managed Care and Drug Abuse Treatment, July 24, 1998.

IV. Measures of Quality Assessment

A. Overview

Managed care has been shown to reduce overall mental health and substance abuse cost and utilization, in part by shifting services from inpatient settings to less costly ambulatory settings. The underpinnings of managed care - case management, utilization review, and standardized criteria - aim for the elimination of services that are unnecessary, overly intensive, and ineffective. However, there is concern about the impact of managed care on quality.

What is quality of care? One definition is: "…the degree to which health services…increase the likelihood of desired health outcomes…"[5] Measurement of care quality must consider:

- The quantity of care;
  - too much; i.e., *unnecessary* care,
  - too little; i.e., insufficient *necessary* care.
- Appropriate care; i.e., *effective* care.
- Human skills; i.e. *expertise.*
- Systems; i.e., ability to *monitor* patients during and after their treatment course.[6]

The classic formulation to quality assessment suggests the use of three categories: *structure, process,* and *outcomes.*[7] This formulation is still, virtually, universally accepted.

Structure addresses providers, both professional and institutional; how they are organized, staffed and located. Acceptable quality measures for professional providers include state licensure, board certification, and training. Similar measures for facilities include licensure, government program certification (e.g., Medicare), accreditation, and physical attributes.

Process addresses both personal and technical aspects of care and is often called "performance" in the jargon. The personal aspect includes patients' experiences with referral processes, appointment scheduling, provider punctuality and provider-patient communication. The technical aspect includes diagnosis timeliness and therapeutic appropriateness, complication rates, and coordination across providers.

Outcomes of care may be assessed using clinical, functional and personal measures. Clinical outcome measures for mental health are related to symptoms, course of treatment, and remission or relapse. Functional outcome measures address patients' daily activities such as the nature of relationships and the ability to earn and/or maintain a living. Personal

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[5] Institute of Medicine. "Medicare: A Strategy for Quality Assurance." K. N. Lohr, ed. National Academy Press. Washington, DC: 1990

[6] Institute of Medicine. "Measuring the Quality of Health Care." Molla S. Donaldson, ed. National Academy Press. Washington, DC: 1999

[7] Donabedian, A. "Evaluating the Quality of Medical Care." Milbank Memorial Fund Quarterly 44:166-203, 1966

measures are less objective and include patients' assessments of both their care and current health status.

In determining what measures to use, two critical questions must be answered:
1. What is the evidence the indicator (measure) predicts better outcomes?
2. What level of the indicator reflects adequate quality; i.e., what is the standard?[8]

There are three issues that must be explored relative to these questions:
1. What is the feasibility of obtaining the necessary data; does it exist? is it accessible? what burdens are associated with obtaining it?
2. How reliable, how valid is the data?
3. What is the evidence of a relationship to outcomes?

For example, in answering the first question, various studies indicate the importance of family involvement (intervention) in the treatment of schizophrenia. In-patients followed for one and two years, relapse rates for patients where family intervention was involved were from one-eighth to one-third of the relapse rates for patients treated individually. These studies led to this recommendation by the Agency for Health Care Policy and Research/National Institute of Mental Health (AHCPR/NIMH) Schizophrenia Patient Outcomes Research Team (PORT):

> "Patients who have on-going contact with their families should be offered a family psychosocial intervention which spans at least nine months and which provides a combination of education about the illness, family support, crisis intervention, and problem solving skills training. Such interventions should also be offered to non-family caregivers."[9]

The studies do not answer the second critical question, however. The appropriate amount (too much, too little) of contact with families is still unclear; i.e., there is no standard.

Quality assessment and reporting systems may be based on administrative claims data or clinical outcome data. While claims-based measures are often - but not always - readily available, some consider them as minimum thresholds of care; i.e., the measures do not permit continuous or comprehensive measurement for quality improvement purposes. Also, claims-based measures do not provide for direct evaluation of patient clinical or functional outcomes.[10] Quality reporting systems based on clinical outcome data are more expensive and complicated but have much greater potential for evaluating the actual impact of programs and practices on patient outcomes. Designing and implementing procedures to collect comprehensive clinical outcome data poses great challenges.

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[8] This discussion draws on a presentation to the Task Force on September 29, 1999 by Anthony Lehman M.D., University of Maryland School of Medicine.

[9] Lehman, Anthony et al, *Schizophrenia Bulletin*, Vol. 24, No. 1, 1998.

[10] National Institutes of Health. "Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access & Quality. An Interim Report to Congress by the National Advisory Mental Health Council." U.S. Department of Health and Human Services. Bethesda, MD. April 1998.

Two organizations using administrative data are National Committee for Quality Assurance (NCQA) through the Health Plan Employer Data and Information Set (HEDIS) and the American Managed Behavioral Healthcare Association (AMBHA) through PERMS 2.0.

Examples of clinical outcome systems include a number developed by managed behavioral healthcare organizations (MBHOs), including MCC Behavioral Health, Magellan Behavioral Health, and United Behavioral Care.

While no longer operational MCC's *Clinical Quality Information System* (CQIS) was integrated into routine clinical operations. Core features included: collection of patients' baseline evaluative data; assessment after six and twelve months; multi-functional patient assessment; and, linkage of outcome data with other databases.

Magellan has developed a *Clinical Information System* that is offered solely to its administrative service clients.

The *Goal-Focused Treatment and Patient Outcome System* (GFTPO) developed by United is a case management system involving clinicians and patients in *psychotherapy*. Integrated into clinical operations, it is designed for quality assessment and improvement of *process* and *outcomes*.

During its deliberations, the Task Force acknowledged the desirability of reporting data that comes from systems based upon or using clinical data such as these systems. Representatives from MBHOs pointed-out, however, that clinically-based information and reporting systems are expensive.

Before a measure is recognized as a quality indicator, it must pass several tests. Suggested hurdles that measures should clear before they are used include:

- clinically meaningful; is the measure associated with the presence or absence of some clinical event or condition?
- validity; does the measure provide information on what it is intended to measure?
- reliability; do repeated observations yield the same result?
- suitability; are the same results observed across all or only some patient subgroups?
- availability; is the measure available and, if not, does the capability exist to obtain it and at what cost?
- cost-effectiveness; does the expected quality improvement justify the cost of obtaining the measure?
- accuracy; how will accuracy be determined?

Consideration must be given to the measure's intended audience. Accrediting bodies focus exclusively on structural and procedural measures. The public, without fully understanding the process or details, may properly assume that accreditation signifies an organization's adherence to practices that assure some degree of quality care. A process to aggregate outcome measures and assign a ranking has not yet been developed so these measures must be reported individually. As a result, the user must be able to comprehend the measure's significance.

Finally, there is the issue of the means used to disseminate the measures. MBHOs could be required to provide these measures upon request or publish them in sales and/or enrollment materials. Other options include publication of performance reports by a government entity or professional association.

B. National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that assesses and reports on the quality of managed care plans. NCQA began accrediting managed care organizations (MCOs) in 1991 and, more recently, managed behavioral health care organizations (MBHOs). About half of America's HMOs, responsible for the health care of three-quarters of all HMO membership, are involved in NCQA Accreditation process. Organizations seeking accreditation must meet NCQA's standards and undergo both an on-site and off-site survey. MCOs must also report HEDIS results – see Part V of this report - and the outcome of at least one patient satisfaction survey. HEDIS reporting and patient satisfaction surveys are not yet required for MBHOs.

The 2000 Surveyor Guidelines for The Accreditation of MBHOs, effective July 1, 2000, contain standards that are roughly equivalent to the standards for MCOs. The standards are organized into the six categories discussed in Table 3.

Table 3
Accreditation Standards

Standard	Goal
Quality Management and Improvement (QI)	Improved quality of clinical care and service.
Utilization Management (UM)	Maximization of care effectiveness; promotion of fair and consistent UM
Credentialing and Recredentialing (CR)	Provision of care effectiveness; promotion of fair and consistent UM
Members' Rights and Responsibilities (RR)	Promotion of effective care and patient satisfaction
Preventive Behavioral Health Services (PH)	Promotion of health and reduction of subsequent inappropriate health care needs of covered population.
Clinical Evaluation and Treatment Records (TR)	Facilitation of communication, coordination, and continuity of care; promotion of efficient and effective treatment.

A MBHO must satisfy several conditions before it is eligible for accreditation. These conditions include:

- Providing, or arranging to provide, through an organized delivery system, these health care services;
  - a defined benefits package including child and adolescent mental health services, adult mental health services, substance abuse and chemical dependency services, and preventive behavioral health services.

  - behavioral health services that are delivered in inpatient, residential, partial hospitalization, and outpatient settings.
- On-going operations for at least eighteen months.

The NCQA survey team reviews a MBHO's quality-related systems and assesses the extent to which they are in compliance with the standards. This assessment includes:

- a review of written documentation and records provided by the MBHO.
- on-site observations by surveyors.
- information gained by surveyors during relevant interviews with staff of the MBHO.
- credentialing files.
- a review of treatment records and utilization management cases.
- an assessment of member service systems, including handling of complaints and appeals, member education and member surveys, as applicable.

The result of the accreditation process is the determination of the accreditation status:

1. ***Full Accreditation***. The MBHO is fully or substantially compliant with the standards in each category. This status is effective for three years after which the MBHO must undergo a full survey.
2. ***One-Year Accreditation***. While significantly compliant, the MBHO is lacking in certain areas but the shortcomings are capable of correction within one year. The MBHO is resurveyed at the end of that year.
3. ***Provisional Accreditation***. The MBHO is partially compliant and the standards not met do not have a bearing on quality of care. This status is effective for fifteen months but the MBHO must be resurveyed within twelve months.
4. ***Denied Accreditation***. Generally, a MBHO denied accreditation must wait one year before it may reapply.

At its discretion, NCQA may review a MBHO during the time its accreditation status is in effect. The purpose of a discretionary review, which may vary in scope across MBHOs, is validation of the existing status. When NCQA decides to perform a discretionary review, the following language is added to the existing status: "NCQA Discretionary Review Pending." A MBHO's status may change as a result of the discretionary review.

NCQA publicizes a MBHO's accreditation status. Explained in general terms are the meanings of the accreditation status categories. Aggregate data on the performance of all organizations surveyed are also published. In Maryland, only one MBHO, Magellan Behavioral Health, is accredited by NCQA.

C. Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit health care standards-setting and accrediting body. The JCAHO accredits more than 18,000 health care organizations, including hospitals, health care networks, MCOs, and behavioral health care organizations. While the JCAHO is able

to trace standard-setting for hospitals back to 1917, distinct accreditation for managed behavioral health care organizations (MBHOs) did not begin until 1997.

Standards that MBHOs must meet to achieve accreditation are contained in JCAHO's Comprehensive Accreditation Manual for Managed Behavioral Health Care (CAMMBHC). The 728 standards are organized into twelve "functional" chapters. Within each chapter, the standards are grouped into "performance areas" considered most critical to a MBHO's overall performance. The twelve functions and the goals of each appear in Table 4.

Table 4
Functional Goals

Function	Goal
Rights, Responsibilities, and Ethics	Improved care, services, and outcomes by respecting each member's human, civil, constitutional, and statutory rights.
Continuum	Care provided that is appropriate to member needs in a continuous and coordinated manner within and among settings.
Assessment	Appropriate care determined through the MBHO's continuous assessment of each member
Care	Individualized, planned, and appropriate interventions.
Education and Communication	Improved health by promoting healthy behavior and appropriately involving members in their care, services, and care decisions.
Improving Delivery System Performance	Continuous improvement of the MBHO's care outcomes and services provided to members.
Leadership	Improved member care, services, and outcomes through effective leadership.
Environment of Care Management	A safe, accessible, effective and efficient environment for members and staff in the care and service settings.
Human Resources Management	Creation of an environment that fosters staff self-development and continued learning to support the MBHO's mission.
Information Management	Collection, management and use of information to improve care and services and the MBHO's performance in clinical, governance, management and support processes.
Infection Surveillance, Prevention and Control	Identification and reduction of risks of endemic and epidemic infections in both members and health care workers.
Behavioral Health Wellness	Address maintenance of health, prevention of illness and impaired functioning, and avoidance or delay of morbidity, disability, and care resource use associated with chronic and degenerative disease.

The extent to which a MBHO meets or is in compliance with the standards is determined through a survey. The survey includes interviews with MBHO leadership, review of documents considered basic data sources, visits to areas in which care and services are provided, review of a representative sample of clinical records, and the opportunity for the public to provide the survey team with relevant information. Start-up MBHOs have the option of requesting two surveys: the first, before patients are treated and the second, four-to-six months later. While two surveys increase accreditation costs significantly, accreditation in short order is possible. At the end of the survey process, an MBHO is provided with one of seven accreditation decisions:

1. Accreditation with Commendation;
2. Accreditation
3. Accreditation with Type I Recommendations[11]
4. Provisional Accreditation[12]
5. Conditional Accreditation[13]
6. Preliminary Nonaccreditation
7. Not Accredited

In addition to surveying the MBHO, a sample of practitioners' offices in the MBHO's delivery system is evaluated using approximately seventy of the standards in the CAMBHC. Any unaccredited care and service providers for which the JCAHO has relevant standards and that are not structurally integrated with a MBHO's central operations are also evaluated. Care and service providers are entities with which the MBHO contracts for specific services; e.g., an outpatient mental health clinic.

Accreditation is valid for three years unless revoked for cause or other reasons. Organizations accredited with type I recommendations are monitored to assure their successful resolution. The monitoring process is determined by the nature of the recommendation. For many recommendations, written progress reports are required while others require an on-site focused survey. The JCAHO may perform an unscheduled or unannounced survey if it becomes aware of potentially serious care and safety issues. Unannounced mid-cycle surveys are also conducted on a 5% random sample of accredited organizations.

The JCAHO is especially vigilant for "sentinel events." These events are unexpected occurrences involving death or serious physical or psychological injury or the risk of its occurrence. An organization may be placed on Accreditation Watch and required to implement corrective measures, evaluate their effectiveness, and provide a written summary of them to the JCAHO. In Maryland, no MBHOs are accredited by JCAHO.

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[11] A type 1 recommendation addresses unsatisfactory compliance in a specific performance area that must be corrected by a stipulated date.

[12] Provisional accreditation is granted to eligible MHBOs who have “passed” the initial survey but have not been surveyed a second time.

[13] Conditional accreditation is assigned to a MBHO not in substantial compliance but believed to be capable of achieving acceptable compliance by a stipulated date.

D. Complaints, Appeals and Grievances as a Quality Indicator

In January 1999, the Maryland Insurance Administration (MIA) implemented an appeals and grievance process passed by the legislature the previous session. The process provides for an external appeal of medical necessity decisions to MIA, after an HMO's internal appeal process is exhausted. The Task Force was briefed in October on complaints referred to MIA that concern managed behavioral health. As of October 1999, there were only thirty-three complaints related to behavioral health. Sixteen of the behavioral health complaints had been resolved, all to the insureds' benefit. Twelve of the sixteen were resolved when the insureds' carriers reversed their original denials; the remaining four cases were resolved by the decision of the MIA. Therefore, the data, at the appeal level, appear to be insufficient to distinguish performance levels among plans using tests of statistical significance. Staff will explore whether complaints received internally by HMOs regarding MBHOs provide useful information. A major problem with use of complaints as a quality indicator, however, is that it penalizes carriers who encourage members to report this information.

E. Discussion

The Task Force has noted that some measures are available; some that it would like to have are unattainable at the present time, and some are unattainable at any time in the near future due to cost and measurement issues. At the present time, structure and process measures are the most easily reported, although outcome measures were preferred by Task Force members as more valid indicators of quality.

Presentations by Faith Couvillon of Magellan Behavioral Health and Felice Tucker of United Behavioral Health also indicated carriers' reporting capabilities depend on how the carriers are structured and whether behavioral health is integrated into the carriers' data system or carved-out. For example, an MBHO that is part of a carve-out arrangement may have referral data on enrollees but may not actually be able to verify that a service was rendered because the HMO processes claims. One carrier testifying before the Task Force indicated about 60% of its business involved assuming risk. However, about one-third of this business did not involve processing claims since capitation was accepted. When no claims data is available to the MBHO due to the MBHO serving in an administrative capacity only or due to capitated risk contracts, there is no means for the MBHO to verify the receipt of services. This could be a significant barrier in reporting. The flow of data between carriers and MBHOs needs to be explored further by the Task Force.

V. Available Data on Managed Behavioral Health

Legislation creating the Task Force requires the consideration of certain data to report on quality. These data include use-of-service measures (discharge, length of stay, readmission) and patient satisfaction. However, this data is only available by HMO not MBHO. Data would need to be aggregated, perhaps over several HMOs to report on MBHOs since they may serve more than one carrier or employer group. Currently, some data is available on use of services, with the exception of readmission rates. There are no generally accepted measures of patient satisfaction although the Consumer Assessment of Health Plan's Behavioral Health Survey (CABHS) is being field tested for use with the generally accepted Consumer Assessment of Health Plans Study (CAHPS). CAHPS 2.0H is required by NCQA for HMO accreditation. The earliest the CABHS survey could be required for use would be 2001 reporting and this date may be optimistic. The Medicaid program has also fielded a patient satisfaction survey. The Task Force was briefed on this survey's content.

Despite the lack of data in the two areas mentioned above, there is data being reported on several effectiveness of care and use-of-service measures by the National Committee for Quality Assurance (NCQA). At this time, this data is reported by an HMO. In the final report, staff will attempt to show whether services were carved-out and identify the data by an MBHO.

NCQA evaluates health plans two different ways: through Accreditation (see Part IV of this Interim Report) and through the use of the Health Plan Employer Data and Information Set (HEDIS - a set of standardized performance measures).

HEDIS 1999 measures clinical performance to provide information to consumers, employers and health plans. The measures are assigned to eight categories or *domains* and to one of two *sets: reporting* or *testing.* The eight domains are:

1. Effectiveness of Care,
2. Access/Availability of Care,
3. Satisfaction with the Experience of Care,
4. Health Plan Stability,
5. Use of Services,
6. Cost of Care,
7. Informed Health Care Choices,
8. Health Plan Descriptive Information.

Effectiveness of Care, contains two mental health measures.

1. *Follow-up after hospitalization for mental illness.* The percentage of members, age six and older, who had an ambulatory or day/night mental health visit within 7 days of hospital discharge; within 30 days of hospital discharge.
2. *Antidepressant medication management.*
   a. The percentage of members age eighteen and older who were diagnosed with a new episode of depression, treated with antidepressant medication, and who had at least three follow-up contacts with a primary care or mental health practitioner

during the twelve-week Acute Treatment Phase. This process measure assesses the adequacy of clinical management of new treatment episodes for adult members with a major depressive order.

b. The percentage of members age eighteen and older who were diagnosed with a new episode of depression, treated with antidepressant medication, and who remained on an antidepressant drug during the entire twelve-week Acute Treatment Phase. This intermediate outcome measure assesses the percentage of adult members initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.
c. The percentage of members age eighteen and older who were diagnosed with a new episode of depression, treated with antidepressant medication, and who remained on an antidepressant drug for at least six months. This intermediate outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen by determining whether adult members completed a period of Continuation Phase Treatment adequate for defining a *recovery* according to AHCPR *Depression in Primary Care*.[14]

Table 5 displays HEDIS 1999 measure "Follow-Up After Hospitalization for Mental Illness" for the fifteen commercial HMOs in Maryland. The tables throughout this section use the following symbols:

● = Plan performed better than the Maryland average
⊙ = Plan performed equivalent to the Maryland average
❍ = Plan performed lower than the Maryland average

[14] *Depression in Primary Care Volume 2* Treatment of Major Depression Clinical Practice Guideline, Number 5. Rockville, MD U S Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research AHCPR Publication No 93-0551 April 1993.

Table 5

Follow-Up Hospitalization for Mental Illness, 1999 Results				
	Percent of HMO Members Who Had a Follow-Up Visit for Mental Illness			
	7 Day Follow-Up Period		30 Day Follow-Up Period	
Maryland HMO Average	*45%*		*63%*	
Aetna US-Maryland	38%	⊙	53%	⊙
Aetna US-Virginia	22%	❍	47%	❍
CapitalCare	39%	⊙	61%	⊙
CIGNA *	52%	●	70%	●
Delmarva *	46%	⊙	59%	⊙
FSHP *	43%	⊙	62%	⊙
GWUHP	54%	⊙	67%	⊙
Innovation	NA		NA	
Kaiser *	62%	●	76%	●
MD-IPA; OCI	56%	●	79%	●
NYLCare	43%	⊙	60%	⊙
PHN	47%	⊙	57%	⊙
Principal	38%	⊙	74%	●
Prudential	43%	⊙	56%	❍
United *	41%	⊙	58%	⊙

Source: HCACC, 1999 Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland

Notes:

Maryland HMO average rate is calculated from the rate of all 15 commercial HMOs operating in Maryland. The rate was not weighted by plan enrollment.

* These plans used the administrative method to calculate this rate. All other plans used the hybrid method.

NA = Not available. The HMO could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

The Maryland average indicates 45% of members received a follow-up visit after hospitalization for mental illness within 7 days. Three plans (Cigna, Kaiser and MD-IPA; OCI) performed significantly better than the Maryland average. One plan, Aetna US – Virginia, performed significantly worse.

Sixty three percent of plans provided follow-up within 30 days of hospitalization. The three plans previously cited and Principal performed significantly better than other plans on this measure. Aetna US – Virginia and Prudential performed significantly worse.

Table 6 displays HEDIS 1999 measure "Antidepressant Medication Management" for the fifteen largest HMOs in Maryland.

Table 6

Antidepressant Medication Management, 1999 Results						
	Percent of HMO Members Taking Medication for Depression					
	Optimal Practitioner Contacts for Medication Mgmt		Effective Acute Phase Treatment		Effective Continuation Treatment	
Maryland HMO Average	*26%*		*53%*		*37%*	
Aetna US-Maryland	NR		NR		NR	
Aetna US-Virginia	NR		NR		NR	
CapitalCare	40%	●	57%	⊙	33%	⊙
CIGNA	32%	⊙	57%	⊙	38%	⊙
Delmarva	6%	❍	20%	❍	26%	❍
FSHP	5%	❍	67%	●	47%	●
GWUHP	7%	❍	70%	●	47%	●
Innovation	NA		NA		NA	
Kaiser	26%	⊙	63%	●	48%	●
MD-IPA; OCI	55%	●	27%	❍	13%	❍
NYLCare	NR		NR		NR	
PHN	NR		NR		NR	
Principal	47%	●	53%	⊙	33%	⊙
Prudential	3%	❍	62%	●	51%	●
United	42%	●	50%	⊙	34%	⊙

Source: HCACC, 1999 Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland

Notes:
Maryland HMO average rate is calculated from the rate of all 15 commercial HMOs operating in Maryland. The rate was not weighted by plan enrollment.
This measure can only be calculated using the administrative method.
NR = Not Reportable. Data did not pass independent audit.
NA = Not available. The HMO could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

This HEDIS measure assesses three different facets of successful pharmacological management of depression. On the first measure, “optimal practitioner contacts,” four plans performed significantly better than the Maryland average (CapitalCare; MD-IPA; OCI; Principal; and United). Four performed significantly below (Delmarva; FSHP; GWUHP; and Prudential). On the other two measures, four plans (FSHP; GWUHP; Kaiser; Prudential) also were significantly above the Maryland average, and two plans were below (Delmarva and MD-IPA; OCI).

On all these HEDIS measures, it is important to bear in mind that the calculation of them may lead to under-reporting due to the small number of people who are hospitalized for mental illness and the fact that services may be carved-out to an MBHO. Historically, plans have not required encounter data from these carved out entities. Moreover, new measures, such as these are often difficult for plans to calculate and verify.
The *Use of Services* domain contains the same two utilization measures for both mental health (MH) and chemical dependency (CD):

1. Inpatient MH/CD discharges per 1,000 members (all members, not just those diagnosed with MH/CD disorders),
2. Average number of days spent in inpatient treatment for MH/CD disorders.

Tables 7.a. and 7.b. display the HEDIS 1999 Use of Services data for mental health and chemical dependency, respectively. These tables display two of the five measures the enabling legislation charges the Task Force to consider.

Table 7.a.

Mental Health Utilization-Inpatient Discharges and Average Length of Stay, 1999 Results		
	Discharges/1,000 members	**Average Length of Stay (days)**
Maryland HMO Average	*3.3*	*5.4*
Aetna US-Maryland	1.5	4.7
Aetna US-Virginia	1.6	5.5
CapitalCare	3.1	5.2
CIGNA	1.9	5.2
Delmarva	3.2	4.8
FSHP	3.7	5.7
GWUHP	2.2	9.6
Innovation	NA	NA
Kaiser	2.8	5.5
MD-IPA; OCI	3.0	6.0
NYLCare	3.2	5.5
PHN	14.2	0.4
Principal	3.3	5.2
Prudential	2.4	5.9
United	3.8	6.3

Source: HCACC, 1999 Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland

Notes:
Maryland HMO average rate is calculated from the rates of all 15 commercial HMOs operating in Maryland. The rate was not weighted by plan enrollment.
NA = Not available. The HMO could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

Table 7.b.

Chemical Dependency-Inpatient Discharges and Average Length of Stay, 1999 Results		
	Discharges/1,000 members	**Average Length of Stay (days)**
Maryland HMO Average	*0.9*	*4.1*
Aetna US-Maryland	0.3	4.9
Aetna US-Virginia	0.7	3.2
CapitalCare	0.6	5.0
CIGNA	0.6	2.4
Delmarva	1.3	4.8
FSHP	1.0	4.7
GWUHP	0.9	6.4
Innovation	NA	NA
Kaiser	1.9	3.3
MD-IPA; OCI	1.1	6.3
NYLCare	0.7	4.0
PHN	1.4	0.5
Principal	1.5	4.0
Prudential	0.5	4.3
United	1.4	4.0

Source: HCACC, 1999 Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland

Notes:
Maryland HMO average rate is calculated from the rates of all 15 commercial HMOs operating in Maryland. The rate was not weighted by plan enrollment.
NA = Not available. The HMO could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

As with other use of service data, there are issues that complicate interpreting whether performance is good or poor. The most useful purpose for this data may be to identify outliers to determine whether problems exist in data collection and measurement or if there are unusually high or low numbers of discharges or length of stay.

The Maryland average was 3.3 inpatient mental health discharges per 1,000 members with an average LOS of 5.4 days. Discharges and LOS for inpatient treatment of chemical dependency were lower at 0.9 per 1,000 members and 4.1 days, respectively.

In addition to the HEDIS data, other potential sources of data for understanding the diagnosis associated with services being delivered and the types of providers rendering care include the MHCC's Maryland Medical Care Data Base and the Health Services Cost Review Commission's hospital database.
The Task Force was concerned that the enabling legislation focuses on measures of inpatient and outpatient utilization whereas much of behavioral health care is provided in *intermediate* facilities; e.g., partial hospitalization and day-night care. Unfortunately, measures applicable to this type of care have not been developed.

VI. Recommendations

In making its initial recommendations, the Task Force discussed and debated a series of key questions in performance reporting (see Appendix C). The Task Force unanimously agreed that performance reports should address the needs of multiple audiences including consumers, providers, businesses, HMOs, and MBHOs. The Task Force also recommends the following:

6. Request permission to delay final recommendations until December 15, 2000. Submit an interim report to the Maryland General Assembly on December 15, 1999.

   Discussion: The bill creating the Task Force did not take effect until October 1, 1999 and includes a final reporting date of December 15, 1999. Even with an ambitious schedule of meeting for two hours every two weeks, the Task Force members do not believe there is adequate time to evaluate potential measures of quality and the feasibility of their implementation.

7. Take a three-pronged approach to quality performance reporting.

   d. Identify in the interim report what is currently available and could be included in the HMO performance report in 2001;

   e. Decide in the final report what types of measures would be desirable and are feasible to develop; and

   f. Identify those indicators that would be desirable to develop, but are not currently feasible to report due to data collection, measurement issues, or cost.

   Discussion: The Task Force has already identified several different measures of structure, process, and outcome. Dr. Anthony Lehman from the University of Maryland School of Medicine and other experts have noted the difficulty of sorting out those measures that actually are indicative of quality or that could drive quality improvement.

   The Task Force needs to pursue the determination of what measures should be reported in an orderly, rational process beginning with what is doable and then developing plans to expand on what already exists. This task must consider measures applicable to intermediate care settings because so much of behavioral health care is provided in these settings.

   While structure and process measures are currently the most prevalent and the easiest to report they are not as directly related to quality as outcomes. Reliable and valid outcome measures are still in the early stage of development and may be complicated by issues of risk adjustment.

8. Indicate the following in the 2001 MHCC HMO report card:

   d. HMOs that have behavioral managed health services in-house versus those who carve out these services;

   e. Mental health related HEDIS measures reported by commercial HMOs; and

   f. Accreditation status for carve-outs.

   Discussion: Following the three pronged approach described above, these measures are either available currently or could be derived in a short time period. Other HEDIS measures tested by NCQA could be added as they are developed and, eventually, a section of the report card might be able to be devoted to behavioral health. Currently, NCQA, JCAHO and other organizations accredit MBHOs.

9. By 2001, attempt to combine and report HEDIS HMO mental health measures by MBHOs.

   Discussion: The Commission should examine whether data collected at the HMO level can be aggregated by MBHOs. There may, however, be problems with this approach since it would leave out the experience of large businesses that contract directly with MBHOs and could not account for variation in benefits offered by employers. While Maryland law mandates mental health parity, this requirement does not apply to plans offered to businesses who are self-insured. One study indicates that while self-insured businesses offer mental health services they do not cover them at parity (Health Care Access & Cost Commission, November 1998).

10. For the final report, the Task Force should:

   a. Explore how to expand quality measures beyond HMOs to fully insured plans;

   e. Determine usefulness and feasibility of collecting outcome measures;

   f. Determine the usefulness and feasibility of collecting information on patient satisfaction; and

   g. Determine the usefulness of reporting internal and external complaints. Internal complaints could be recorded and categorized by MBHOs; external complaints could be obtained from the MIA through their Appeals and Grievance Process or the Department of Health and Mental Hygiene.

   Discussion: The four areas described above were briefly discussed during the meetings of the Task Force. In these discussions, it became apparent that more research is needed on these topics before they can be evaluated.